**** This form applies only to the ARRA Premium Reduction ****

FORM FOR SWITCHING COBRA BENEFIT OPTIONS

Instructions: To change the benefit option(s) for your COBRA continuation coverage to something different from what you had on the last day of employment, complete this form and return it to your former employer at the address listed below. **Under federal law, you have 90 days after the date of this notice to decide whether you want to switch benefit options. The effective date for the new coverage option will be the first of the month following receipt of this form.**

Send completed form to: [*insert Employer contact name and address*]

This form must be completed and returned by mail or hand-delivery no later than [*enter date*]. (If mailed, it must be postmarked by this date. If hand-delivered, it must be received at the address above by this date.)

THIS IS NOT YOUR ELECTION NOTICE
YOU ALSO MUST COMPLETE AND RETURN THE COBRA NOTICE OF ELECTION FORM TO SECURE YOUR COBRA CONTINUATION COVERAGE.

I (We) would like to change the COBRA continuation coverage option(s) in the State of South Carolina Employee Insurance Program (the Plan) as indicated below:

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

Old Coverage Option: _____

New Coverage Option: _____

b. _____

Old Coverage Option: _____

New Coverage Option: _____

c. _____

Old Coverage Option: _____

New Coverage Option: _____

_____ _____
Signature Date

_____ _____
Print Name Relationship to individual(s) listed above

_____

_____

_____ _____
Print Address Telephone number